ARH1.0001223792		**Name**	Mr. SAHANI BAIJANATH		
	Patient Identifier	ARHIP53526		**Age**	52Yr 2Mth 10Days
	Sex	Male		**Date of Admission**	09-Nov-2021
	Date of Discharge	10-Nov-2021			
	MLC No				
	Address	HUSNABAD,SIDDIPET,Karimnagar,Tela ngana		**Ward/Bed No**	First Floor, Day Care, Bed no:DC 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

CAD UNSTABLE ANGINA.
CAG DONE ON 09/11/2021.
PLAN FOR MEDICAL MANAGEMENT.

C/o chest pain since few days a/w mild sweating

AT ADMISSION:
Pt conscious, coherent
Afebrile
PR: 58/min
BP: 120/70mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 99%
P/A: Soft

A 52 years old male patient Mr. SAHANI BAIJANATH came with c/o chest pain since few days a/w mild sweating. All necessary investigations were done and diagnosed as CAD UNSTABLE ANGINA. CAG DONE ON 09/11/2021- CAD-TVD (LAD, LCX, RCA), left dominant system. PLAN FOR MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
5. TAB: MONIT GTN 2.6MG TWICE DAILY AT 8AM 8PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

ARH1.0001185999		**Name**	Mr. THANDRA HARIBABU		
	Patient Identifier	ARHIP54383		**Age**	21Yr 11Mth 13Days
	Sex	Male		**Date of Admission**	18-Jan-2022
	Date of Discharge				
	MLC No				
	Address	2-99,BADDIPALLY,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 7
	Primary Consultant	Dr Chandra Shekar Sathineni			

SYNCOPE FOR EVALUATION
S/P CRANIOTOMY

Alleged history of slip and fall at home and sustained injury over head followed by seizures 2-3 episodes.

Known case of post craniotomy in 2019 for left temporo-parietal bleed with mass effect

AT ADMISSION:
Afebrile
PR: 108/min
BP: 100/60mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 96%
P/A: Soft

A 21 years old male patient Mr. THANDRA HARIBABU came with c/o alleged history of slip and fall at home and sustained injury over head followed by seizures 2-3 episodes. Known case of post craniotomy in 2019 for left temporo-parietal bleed with mass effect. All necessary investigations were done and diagnosed as SYNCOPE FOR EVALUATION, OLD CASE OF S/P CRANIOTOMY. Managed conservatively. Patient condition and need for further hospitalization clearly explained to patient attendants but they want to leave against medical advice so patient being discharged under LAMA.

ARH1.0001224802		**Name**	Mr. GORITYLA JANARDHAN		
Patient Identifier	ARHIP53852			**Age**	76Yr 0Mth 4Days
Sex	Male			**Date of Admission**	04-Dec-2021
Expired Date	04-Dec-2021				
MLC No					
Address	KOHEDA,Karimnagar,Telangana			**Ward/Bed No**	First Floor, MICU, Bed

no:MIC U 2

Primary Consultant	DR. SRI KARAN UDDESH -- INTERNAL MEDICINE	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

HYPOVOLEMIC SHOCK SECONDARY TO HEMATEMESIS, S/P CPR STATUS.

C/o 2 episodes of blood vomitings
H/o Recently treated pulmonary embolism
Old CVA in 2019

ON ADMISSION VITAL

Patient drowsy
PR-30/min
BP- Not recordable
RR-22/min
RS-BAE+,
CVS-S1S2+
P/A-Soft
SPO2-70%

A 76 years old male patient Mr. GORITYLA JANARDHAN came with c/o 2 episodes of blood vomitings
H/o Recently treated pulmonary embolism, Old CVA in 2019. All necessary investigations were done and diagnosed as HYPOVOLEMIC SHOCK SECONDARY TO HEMATEMESIS, S/P CPR STATUS. Managed conservatively. Patient condition and prognosis was explained to patient attendants. On 04/12/2021 at 12.00 PM patient went to bradycardia CPR started according to ACLS guidelines. inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 12.51 PM on 04/12/2021.

CAUSE OF DEATH:

CARDIOPULMONARY ARREST SECONDARY TO HYPOVOLEMIC SHOCK SECONDARY TO HEMATEMESIS, S/P CPR STATUS.

ARH1.0001226546		**Name**	Mrs. GANGU BAI S		
Patient Identifier	ARHIP54322		**Age**	67Yr 0Mth 2Days
Sex	Female		**Date of Admission**	13-Jan-2022
Expired Date	14-Jan-2022			
MLC No				
Address	KORUTLA,JAGTIAL,Other,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
CAD ACUTE IWSTEMI CAG(DVD)S/P PTCA+DES TO RCA DONE ON(14/1/22)CARDIOGENIC SHOCK.	

C/o Left sided chest pain

AT ADMISSION:
PR: 74/min
BP: 110/70 mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 98%
P/A: Soft

A 67 years old female patient GANGU BAI came with c/o left sided chest pain. All necessary investigations were done and diagnosed as CAD ACUTE IWSTEMI CAG(DVD)S/P PTCA+DES TO RCA DONE ON (14/1/22) CARDIOGENIC SHOCK. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes,

according to ACLs guidelines. patient developed bradycardia, CPR was continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 7.00 PM on 14/01/2022

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO CAD ACUTE IWSTEMI CAG(DVD)S/P PTCA+DES TO RCA DONE ON (14/01/2022) CARDIOGENIC SHOCK

ARH1.0001226636	**Name**	Mrs. HASHMATH BEGUM			
	Patient Identifier	ARHIP54352		**Age**	55Yr 0Mth 0Days
	Sex	Female		**Date of Admission**	16-Jan-2022
	Expired Date	16-Jan-2022			
	MLC No				
	Address	H.NO:15-3-594,LB NAGAR,GODAVARIKHANI,RAMAGUNDAM,PEDDAPALLY,Other,Telangana		**Ward/Bed No**	Ground Floor, Emergency Ward, Bed no:EME 3
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Add Diagnosis

Disease	Disease Type
CAD ACUTE IWSTEMI,COMPLETE HEART BLOCK S/P TPI+PTCA+DESTO RCA(16/01/2022).	

Chest pain since 9 mm
Known case of diabetic mellitus, hypertension and regular medication

AT ADMISSION:
Patient is drowsy, coherent
PR: 42 /min
SBP: 60mmHg
CVS: S1S2

RR: 18/min
SPO2: 96% on room air
P/A: Soft, BS+ 22

ARH1.0001226697	**Name**	Mrs. D MALLAKKA			
	Patient Identifier	ARHIP54373		**Age**	65Yr 0Mth 3Days
	Sex	Female		**Date of Admission**	18-Jan-2022
	Date of Discharge				
	MLC No				
	Address	gundaram,kamanpur,peddapally,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 6
	Primary Consultant	Dr. Vidya Sagar A--			

CORONARY ARTERY DISEASE, AWMI, NO TLT
SR, MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]
CORONARY ANGIOGRAM (20/01/2022) - NORMAL CORONARIES
PLAN MEDICAL MANAGEMENT
R/F : HTN

C/o chest pain since 2 days radiating to neck and back

AT ADMISSION:
Pt conscious, coherent
Afebrile
PR: 70/min
BP: 100/70mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 99%
P/A: Soft

A 65 years old female patient Mrs. D MALLAKKA came with c/o chest pain since 2 days radiating to neck and back. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%], CORONARY ANGIOGRAM (20/01/2022) - NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. 1 unit RBC transfusion given. Patient is being

discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:
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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB: EMBETA-XR 25MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB: RAMISTAR 2.5MG TWICE DAILY AT 8AM AT 8PM TO CONTINUE.
6. TAB: FRUSELAC ONCE DAILY AT 8AM TO CONTINUE.
7. TAB: RANTAC 150 MG TWICE DAILY AT 8AM AT 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001138156		**Name**	Mr. SRINIVAS GADDE
Patient Identifier	ARHIP54374	**Age**	50Yr 4Mth 25Days
Sex	Male	**Date of Admission**	18-Jan-2022
Date of Discharge			
MLC No			
Address	3-42/1 REKURTHI,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 8
Primary Consultant	Dr. Vidya Sagar A		

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT
SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%
R/F: HTN, T2DM
OLD CAD, S/P PTCA+DES TO RCA WITH BIOMIME 3.0 X 19 mm (27/08/2017)
CORONARY ANGIOGRAM DONE ON 18/01/2022 – CAD-SVD (RCA)
PRIMARY PTCA+DES TO RCA WITH 2.75 X 32 MM METAFOR DONE ON 18/01/2022

C/o chest pain since 11.30 pm on 18/01/2022, radiating to back and left arm associated with mild sweating

AT ADMISSION:
Afebrile
PR: 72/min
BP: 120/80mmHg
RS: BAE+
CVS: S1S2
RR: 20/min
SPO2: 99%
P/A: Soft

A 50 years old male patient Mr. SRINIVAS GADDE came with c/o chest pain since 11.30 pm on 18/01/2022, radiating to back and left arm associated with mild sweating. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, R/F: HTN, T2DM, OLD CAD, S/P PTCA+DES TO RCA WITH BIOMIME 3.0 X 19 mm (27/08/2017), CORONARY ANGIOGRAM DONE ON 18/01/2022 – CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 2.75 X 32 MM METAFOR DONE ON 18/01/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2) TAB. AXCER 90MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4) TAB. LIPRIL 5 MG ONCE DAILY AT 8AM TO CONTINUE.
5) INJ. LANTUS 20 Units S/C ONCE DAILY AT 8PM TO CONTINUE.
6) TAB. PROLOMET XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
7) TAB. ISTAMET 50/1000 ONCE DAILY AT 8AM TO CONTINUE.
8) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.
EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.
EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.
SEVERE PAIN AT THE OPERATED SITE.
DISCOLORATION AND SWELLING OF THE OPERATED SITE.
BLEEDING FROM THE OPERATED SITE.
CHEST PAIN.
ACUTE SHORTNESS OF BREATH.
ALTERED LEVEL OF CONSCIOUSNESS.
LOW URINE OUTPUT IN LAST 24 HOURS.
FEVER ABOVE (101'F).
NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.
WORSENING OF ANY OF YOUR SYMPTOMS
ANY OTHER SIGNIFICANT COMPLAINTS.
---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.
---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001063752		**Name**	Mrs. N MALLESWARI
Patient Identifier	ARHIP54416	**Age**	56Yr 4Mth 29Days
Sex	Female	**Date of Admission**	21-Jan-2022
Date of Discharge			
MLC No			
Address	VIDYA NAGAR,Karimnagar,Andhra Pradesh	**Ward/Bed No**	First Floor, Day Care, Bed no:DC 2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

POSTPRANDIAL ANGINA
TYPE-II DM
OSTEOARTHRITIS KNEE (LEFT > RIGHT)
CORONARY ANGIOGRAM (21/01/2021) - NORMAL CORONARIES
PLAN MEDICAL MANAGEMENT

C/o chest pain since 2 days

AT ADMISSION:
Pt conscious, coherent
Afebrile
PR: 70/min
BP: 110/70mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 99%
P/A: Soft

A 56 years old female patient Mrs. N MALLESWARI came with c/o chest pain since 2 days. All necessary investigations were done and diagnosed as POSTPRANDIAL ANGINA, TYPE-II DM
OSTEOARTHRITIS KNEE (LEFT > RIGHT), CORONARY ANGIOGRAM (21/01/2021) - NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT .

Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:
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1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 20MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. DILZEM-SR 90MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. ISTAMET 50/500 ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. ISTAMET 50/1000 ONCE DAILY AT 2PM TO CONTINUE.
6. INJ: WOSULIN 30/70 TWICE DAILY 26U AT 8AM, 22U AT 8PM TO CONTINUE.
7. TAB: VELOZ 20MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001226636	**Name**	Mrs. HASHMATH BEGUM	
Patient Identifier	ARHIP54352	**Age**	55Yr 0Mth 0Days
Sex	Female	**Date of Admission**	16-Jan-2022
Expired Date	16-Jan-2022		
MLC No			
Address	H.NO:15-3-594,LB NAGAR,GODAVARIKHANI,RAMAGUNDAM,PEDDAPALLY,Other,Telangana	**Ward/Bed No**	Ground Floor, Emergency Ward, Bed no:EME 3
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	**Anesthesiologists**	

Diagnosis

Diagnosis

Add Diagnosis

Disease	Disease Type
CAD ACUTE IWSTEMI,COMPLETE HEART BLOCK S/P TPI+PTCA+DESTO RCA(16/01/2022).	

C/o Chest pain since 9 AM on 16/01/2022
Known case of diabetic mellitus, hypertension and regular medication

AT ADMISSION:
Patient is drowsy, coherent
PR: 42 /min
SBP: 60mmHg
CVS: S1S2
RR: 18/min
SPO2: 96% on room air
P/A: Soft, BS+

A 55 years old female patient Mrs. HASHMATH BEGUM came with c/o chest pain since 9 AM on 16/01/2022. All necessary investigations were done and diagnosed as CAD ACUTE IWSTEMI,COMPLETE HEART BLOCK S/P TPI+PTCA+DESTO RCA (16/01/2022). Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. Patient developed bradycardia, CPR was continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 8.54 PM on 16/01/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO CAD ACUTE IWSTEMI,COMPLETE HEART BLOCK S/P TPI+PTCA+DESTO RCA(16/01/2022).

ARH1.0001226158

Name	Mrs. LAVANYA K		
Patient Identifier	ARHIP54203	**Age**	47Yr 0Mth 3Days
Sex	Female	**Date of Admission**	03-Jan-2022
Expired Date	06-Jan-2022		
MLC No			
Address	CHENJERLA, MANAKONDUR,,Karimnagar,Telangana	**Ward/Bed No**	First Floor, MICU, Bed no:MICU 4
Primary Consultant	DR. SRI KARAN UDDESH -- INTERNAL MEDICINE	**Consultants**	
Surgeons		**Anesthesiologists**	

Diagnosis

Diagnosis

SEPSIS AND CARDIOGENIC SHOCK, FULMINANT MYOCARDITIS

C/o fever with chills since 5 days
K/c/o Br.Asthma

ON ADMISSION VITAL

PR-148/min
BP-80/60mmhg
RR-24/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-70% on FIO2

A 47 years old female patient Mrs. LAVANYA K presented with the above-mentioned complaints patient had haemodynamically unstable VT. Patient was cardioverted patient was started on dual ionotropic support. The patient was connected to mechanical ventilator. Sr. Procalcitonin was low and BP was continuously, non-recordable despite dual ionotropic support, patient has decreased urine output and nephrology consultation was taken and advice was followed. Cardiology consultation was taken and advice was followed. In view of procalcitonin being low and 2D echo showing severe LV dysfunction. A probable fulminant myocarditis diagnosis was made and patient was given INJ. Methylpred 1 g IV OD for 3 days SLED was advised by Nephrologist 1 cycle of SLED was done throughout the hospital stay, patient's BP did not improve patient's clinical status did not improve. On 06/01/2022 patient had a sudden cardiac arrest, CPR was initiated according to ACLS guidelines, despite best efforts patient could not be revived and was hence spiculated at 3.44 AM on 06/01/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO SEPSIS AND CARDIOGENIC SHOCK, FULMINANT MYOCARDITIS

ARH1.0001226911		**Name**	Mr. K SHIVA KUMAR REDDY		
	Patient Identifier	ARHIP54438		**Age**	24Yr 0Mth 1Days
	Sex	Male		**Date of Admission**	21-Jan-2022
	Date of Discharge				
	MLC No				
	Address	VEDIRA KARIMNAGAR ,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, HDU, Bed no:HDU 9
	Primary Consultant	Dr Chandra Shekar Sathineni			

ANGIOEDEMA

C/o sudden facial swelling, shortness of breath

AT ADMISSION:
Afebrile
PR: 98/min
BP: 110/70mmHg
RS: BAE+
CVS: S1S2
RR: 20/min
SPO2: 98% on room air
P/A: Soft,

A 24 years old male patient Mr. K SHIVA KUMAR REDDY came with c/o sudden facial swelling, shortness of breath. All necessary investigations were done and diagnosed as ANGIOEDEMA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:
---
1) TAB. ATARAX 25 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001179717			**Name**	Mr. UTKAM VENKATI	
Patient Identifier	ARHIP54388			**Age**	46Yr 6Mth

			7Days
Sex	Male	**Date of Admission**	19-Jan-2022
Date of Discharge			
MLC No			
Address	1-32/2,CHINTAL PET,METPALLE,Karimnagar,Telangana	**Ward/ Bed No**	First Floor, CICU , Bed no:CICU12
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, UNSTABLE ANGINA
SR, NORMAL LV SYSTOLIC FUNCTION, EF-60%
OLD AWMI, S/P PTCA+DES TO PROXIMAL LAD WITH 3.0 X 23 MM PRONOVA CC, MID LAD WITH 2.75 X 33 mm PRONOVA CC & POBA TO D1 (22/07/2019),
CORONARY ANGIOGRAM DONE ON 18/01/2022 – CAD-SVD (RCA)
PTCA+DES TO RCA-MID WITH 3.0 X 40 MM METAFOR, RCA-PROXIMAL WITH 3.5 X 19 MM METAFOR DONE ON 19/01/2022

C/o chest pain since 8 AM on 18/01/2022

AT ADMISSION:
Afebrile
PR: 72/min
BP: 130/90mmHg
RS: BAE+
CVS: S1S2
RR: 20/min
SPO2: 99%
P/A: Soft

A 46 years old male patient Mr. UTKAM VENKATI came with c/o chest pain since 8 AM on 18/01/2022 . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, NORMAL LV SYSTOLIC FUNCTION, EF-60%, OLD AWMI, S/P PTCA+DES TO PROXIMAL LAD WITH 3.0 X 23 MM PRONOVA CC, MID LAD WITH 2.75 X 23 mm PRONOVA CC & POBA TO D1 (22/07/2019), CORONARY ANGIOGRAM DONE ON 18/01/2022 – CAD-SVD (RCA), PTCA+DES TO RCA-MID WITH 3.0 X 40 MM METAFOR, RCA-PROXIMAL WITH 3.5 X 19 MM METAFOR DONE ON 19/01/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.
EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.
EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.
SEVERE PAIN AT THE OPERATED SITE.
DISCOLORATION AND SWELLING OF THE OPERATED SITE.
BLEEDING FROM THE OPERATED SITE.
CHEST PAIN.
ACUTE SHORTNESS OF BREATH.
ALTERED LEVEL OF CONSCIOUSNESS.
LOW URINE OUTPUT IN LAST 24 HOURS.
FEVER ABOVE (101'F).
NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.
WORSENING OF ANY OF YOUR SYMPTOMS
ANY OTHER SIGNIFICANT COMPLAINTS.
---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.
---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001226892	**Name**	Mrs. BADE SWAPANA			
	Patient Identifier	ARHIP54427		**Age**	38Yr 2Mth 1Days
	Sex	Female		**Date of Admission**	21-Jan-2022
	Date of Discharge	21-Jan-2022			
	MLC No				
	Address	2-87/1, KANAGARTHI RAJANNA 9949351132,Telangana		**Ward/Bed No**	First Floor, CICU , Bed no:CICU12
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

ATYPICAL CHEST PAIN WITH ECG CHANGES,NORMAL LV DYSFUNCTION, CAG DONE ON (21/01/2022) -NORMAL CORONARIES, PLAN;MEDICAL MANAGEMENT

C/o chest pain radiating to back since 3 days

AT ADMISSION:
Pt conscious, coherent
Afebrile
PR: 78/min
BP: 90/60mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 98%
P/A: Soft

A 38 years old female patient Mrs. BADE SWAPANA came with c/o chest pain radiating to back since 3 days. All necessary investigations were done and diagnosed as

ATYPICAL CHEST PAIN WITH ECG CHANGES,NORMAL LV DYSFUNCTION, CAG DONE ON (21/01/2022) NORMAL CORONARIES, PLAN;MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. ECOSPRIN-AV 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. DILZEM SR 90MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001226834		**Name**	Mr. DHARAVATH PRAKASH		
	Patient Identifier	ARHIP54426		**Age**	46Yr 3Mth 2Days
	Sex	Male		**Date of Admission**	21-Jan-2022
	Date of Discharge				
	MLC No				
	Address	8-102, MANAL NIZAMABAD 9493606523 ,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU13
	Primary Consultant	Dr. Vidya Sagar A--			

CORONARY ARTERY DISEASE , NSTEMI
SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF- 30%
OLD CAD, S/P PTCA+DES TO LAD (2011)
CORONARY ANGIOGRAM DONE ON 21/01/2022 – CAD-TVD (LAD,LCX,RCA)
PLAN CABG.
R/F HTN, DENOVO T2DM

C/o chest pain since 21/01/2022

At Admission
Afebrile
PR: 70/min
BP: 110/70 mmHg
RR-20/min
RS: BAE+
CVS: S1S2
P/A: Soft
SPO2-99%

A 46 years old male patient Mr. DHARAVATH PRAKASH came with c/o chest pain since 21/01/2022. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , NSTEMI, SR, SEVERE LV SYSTOLIC

DYSFUNCTION, EF- 30%, OLD CAD, S/P PTCA+DES TO LAD (2011), CORONARY ANGIOGRAM DONE ON 21/01/2022 – CAD-TVD (LAD,LCX,RCA), PLAN CABG, R/F HTN, DENOVO T2DM. Patient is planned for CABG. CTVS consultation taken and advice followed. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:
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1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. ANZISPAN-TR 2.5 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
5. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 7 DAYS.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001226503	**Name**	Mr. VENKATA CHARY V			
	Patient Identifier	ARHIP54315		**Age**	53Yr 0Mth 11Days
	Sex	Male		**Date of Admission**	12-Jan-2022
	Date of Discharge	12-Jan-2022			
	MLC No				
	Address	LINGAMPET, JAGITIAL,Karimnagar,Telangana		**Ward/Bed No**	First Floor, Day Care, Bed no:DC 3
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		**Consultants**	
	Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type

CAD-UNSTABLE ANGINA,SR NORMAL LVFUNCTION
R/F HYPERTENSION ON REGULAR MEDICATION
CAG DONE ON(12/01/22) CAD-RCA MILD DISEASE
ADVICE MEDICAL MANAGEMENT

C/o chest pain (non radiating) a/w palpitations since 1 month

AT ADMISSION:
Pt conscious, coherent
Afebrile
PR: 86/min
BP: 150/90mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 96%

P/A: Soft

A 53 years old male patient Mr. VENKATA CHARY V came with c/o chest pain (non radiating) a/w palpitations since 1 month . All necessary investigations were done and diagnosed as CAD-UNSTABLE ANGINA,SR NORMAL LVFUNCTION, R/F HYPERTENSION ON REGULAR MEDICATION, CAG DONE ON(12/01/22) CAD-RCA MILD DISEASE, ADVICE MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

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1. TAB. TAZLOC TRIO 40MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. CLOPITAB-CV 20MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001226833		**Name**	Mr. GOGU PRATAP REDDY		
	Patient Identifier	ARHIP54400		**Age**	55Yr 9Mth 2Days
	Sex	Male		**Date of Admission**	20-Jan-2022
	Date of Discharge				
	MLC No				
	Address	5-39, NIMMAPALLE RAJANNA 9550043992,Telangana		**Ward/ Bed No**	First Floor, MICU, Bed no:MICU 4
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE , EVOLVED AWMI
SR, NORMAL LV SYSTOLIC FUNCTION, 60%
CORONARY ANGIOGRAM DONE ON 22/01/2022 – CAD-DVD (LAD,RCA)
PLAN PTCA+DES TO LAD/RCA.

C/o chest pain since 2 days

At Admission
Afebrile
PR: 70/min
BP: 100/60 mmHg
RR-20/min
RS: BAE+
CVS: S1S2
P/A: Soft
 SPO2-100%

A 55 years old male patient Mr. GOGU PRATAP REDDY came with c/o chest pain since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , EVOLVED AWMI, SR, NORMAL LV SYSTOLIC FUNCTION, 60%, CORONARY ANGIOGRAM DONE ON 22/01/2022 – CAD-DVD (LAD,RCA), PLAN PTCA+DES TO LAD/RCA. Now

patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:
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1. CAP. ECOSPRIN –AV 150/20 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. RAMISTAR 25 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ANGISPAN TR 2.5 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
4. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 7 DAYS

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001124551		**Name**	Mr. R RAMMOHAN RAO
Patient Identifier	ARHIP54377	**Age**	71Yr 11Mth 6Days
Sex	Male	**Date of Admission**	18-Jan-2022
Date of Discharge			
MLC No			
Address	MARUTHI RESIDENCY,MUKARAMPURA,Karimnagar,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 1
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
Surgeons			

ADHF WITH SEVERE LV SYSTOLIC DYSFUNCTION, EF-24%
OLD CAD, S/P PTCA+DES TO LAD (2019)
R/F : HTN
PARKINSON'S DISEASE
AF WITH FVR

C/o severe SOB since 6 AM on 18/01/2022 a/w profuse sweating

AT ADMISSION:
Pt conscious, coherent
Afebrile
PR: 72/min
BP: 110/60mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 99%
P/A: Soft

A 71 years old male patient Mr. R RAMMOHAN RAO came with c/o severe SOB since 6 AM on 18/01/2022 a/w profuse sweating. All necessary investigations were done and diagnosed as ADHF WITH SEVERE LV SYSTOLIC DYSFUNCTION, EF-24%, OLD CAD, S/P PTCA+DES TO LAD (2019), R/F : HTN, PARKINSON'S DISEASE, AF WITH FVR. Patient is being

discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:
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1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. IXAROLA 15MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 10MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BISONEXT 5MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. NEXPRO 40MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. LANOXIN 0.25MG ONCE DAILY AT 2PM TO CONTINUE (5/7 DAYS).
7. TAB. VESBAL 24MG ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. SYNDOPA PLUS ½ TAB THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
9. TAB: DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
10. SYP. ASCORYL-D 10 ml THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS
11. NEOSPRIN POWDER FOR L/A

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001203523	**Name**	Mr. GANGARAPU MOGILI			
	Patient Identifier	ARHIP54252		**Age**	51Yr 0Mth 5Days
	Sex	Male		**Date of Admission**	06-Jan-2022
	Date of Discharge				
	MLC No				
	Address	2-10-904/1,JYOTHINAGAR,Karimnagar,Telangana		**Ward/Bed No**	First Floor, MICU, Bed no:MICU 4
	Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY		**Consultants**	
	Surgeons			**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
.	

POSTERIOR CIRCULATION STROKE WITH UNCONTROLLED TYPE II DM, S/P CABG

Complaint of giddiness since 6.1.2022 associated with vomiting, slurring of speech and cough.

ON ADMISSION

Pt is drowsy.
Afebrile
PR-77/min
BP-160/100mmhg
RR-20/min
RS-BAE+,
CVS-S1S2+
P/A-Soft, BS+
SPO2-100%

A 51 years old male patient Mr. GANGARAPU MOGILI is a k/c/o HYPERTENSION and TYPE II DIABETES MELLITUS and s/o CABG presented to hospital with c/o giddiness since 6.1.2022 associated with vomiting, slurring of speech and cough. All necessary investigations were done and diagnosed as MULTIPLE ACUTE INFARCTS IN POSTERIOR CIRCULATION. General physician consultation was taken and advise followed. 2D Echo report showed Concentric LVH, s/p CABG, paradoxical septal motion, Grade I diastolic dysfunction, mild LV dysfunction, EF-45%. Managed conservatively. On 19/01/2022 Patient went to bradycardia. CPR started according to ACLS guidelines. Inj.Adrenaline & Inj Atropine given, but patient not revived, then 3 cycles of CPR done Inj.Adrenaline & Inj Atropine repeated, CPR continued. Patient not revived
Rhythm was pulse
Despite efforts, patient could not be revived back, rhythm was asystole
ECG showed flat lines
Pupils-b/l dilated and fixed
Hence patient was declared as dead at 7.19 AM

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO POSTERIOR CIRCULATION STROKE WITH UNCONTROLLED TYPE II DM, S/P CABG

IT PROBLEM

ARH1.0001226909	**Name**	Mrs. PONNALA PREMALATHA			
	Patient Identifier	ARHIP54436		**Age**	48Yr 0Mth 1Days
	Sex	Female		**Date of Admission**	21-Jan-2022
	Date of Discharge				
	MLC No				
	Address	MIRZAPUR,HUSNABAD,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 9
	Primary Consultant	Dr. GOUTHAM ROY			

LEFT THIGH AND GLUTEAL SEBACEOUS CYST
SURGERY: LEFT THIGH AND GLUTEAL SEBACEOUS CYST EXCISION DONE ON 22/01/2022

C/o left thigh subcutaneous cyst with left gluteal lipoma

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c
afebrile
PR-82/min
BP-110/70mmhg
RR-20/min
RS-BAE+
CVS-S1S2+
CNS-NAD.
SPO2-98%

A 48yr old female Mrs. PONNALA PREMALATHA came with c/o left thigh subcutaneous cyst with left gluteal lipoma. All necessary investigations done and diagnosed as LEFT THIGH AND GLUTEAL SEBACEOUS CYST, SURGERY: LEFT THIGH AND GLUTEAL SEBACEOUS CYST EXCISION DONE ON 22/01/2022. Findings: Cyst excised in total, wound closure done. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: NDQ10 ONCE DAILY AT 2PM FOR 1 MONTH
3. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
4. GLUTA VAULT SACHETS ONCE DAILY FOR 15 DAYS

Review after 7 days in General Surgery OPD.

ARH1.0001226614		**Name**	Mr. LAKSHMAREDDY REKULA		
	Patient Identifier	ARHIP54342		**Age**	60Yr 0Mth 8Days
	Sex	Male		**Date of Admission**	15-Jan-2022
	Date of Discharge				
	MLC No				
	Address	GANGADHARA,Telangana		**Ward/ Bed No**	Second Floor, Male General Ward, Bed no:GW17
	Primary Consultant	Dr. Vidya Sagar A--			

CORONARY ARTERY DISEASE, NSTEMI
SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%
CORONARY ANGIOGRAM DONE ON 20/01/2022 – CAD-DVD (LCX, RCA)
PTCA+DES TO MID LCX WITH METAFOR 3.0 X 24 MM AND PROXIMAL LCX WITH METAFOR 3.5 X 13 MM
DONE ON 20/01/2022

C/o left sided chest pain radiating to left arm since 14/01/2022

AT ADMISSION:
Afebrile
PR: 82/min
BP: 110/70mmHg
RS: BAE+
CVS: S1S2
RR: 20/min
SPO2: 99%
P/A: Soft

A 60 years old male patient Mr. LAKSHMAREDDY REKULA came with c/o left sided chest pain radiating to left arm since 14/01/2022. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 20/01/2022 – CAD-DVD (LCX, RCA), PTCA+DES TO MID LCX WITH METAFOR 3.0 X 24 MM AND PROXIMAL LCX WITH METAFOR 3.5 X 13 MM DONE ON 20/01/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
4) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
5) TAB. BETALOC 25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
6) TAB. ANGISPAN-TR 2.5MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.
EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.
EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.
SEVERE PAIN AT THE OPERATED SITE.
DISCOLORATION AND SWELLING OF THE OPERATED SITE.
BLEEDING FROM THE OPERATED SITE.
CHEST PAIN.
ACUTE SHORTNESS OF BREATH.
ALTERED LEVEL OF CONSCIOUSNESS.
LOW URINE OUTPUT IN LAST 24 HOURS.
FEVER ABOVE (101'F).
NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.
WORSENING OF ANY OF YOUR SYMPTOMS
ANY OTHER SIGNIFICANT COMPLAINTS.
---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.
---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001226095		**Name**	Mrs. FARHA NAAZ		
	Patient Identifier	ARHIP54378		**Age**	24Yr 0Mth 23Days
	Sex	Female		**Date of Admission**	18-Jan-2022
	Date of Discharge				
	MLC No				
	Address	WANKDI ,Nirmal,Telangana		**Ward/ Bed No**	Second Floor, Female General Ward, Bed no:GW 5
	Primary Consultant	Dr. SURESH GOUD S			

UROSEPSIS
CONSERVATIVE MEDICAL MANAGEMENT

C/o low backache and left flank pain
S/P Right pushback PCNL + DJ stenting done on 03/01/2022

AT ADMISSION:
Afebrile
PR: 76/min
BP: 130/80mmHg
RS: BAE+
CVS: S1S2
RR: 20/min
SPO2: 98%
P/A: Soft, BS+

A 24 years old female patient Mrs. FARHA NAAZ presented to hospital with c/o low backache and left flank pain, S/P right pushback PCNL + DJ stenting done on 03/01/2022. All necessary investigations were done and diagnosed as UROSEPSIS, CONSERVATIVE MEDICAL MANAGEMENT. Patient discharged in hemodynamically stable condition with required medication and advice.

ARH1.0001226908		**Name**	Mr. SHIVA KUMAR J		
	Patient Identifier	ARHIP54440		**Age**	33Yr 0Mth 2Days
	Sex	Male		**Date of Admission**	22-Jan-2022
	Date of Discharge				
	MLC No				
	Address	PEDDAPALLI,,Karimnagar,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:118 A
	Primary Consultant	Dr Chandra Shekar Sathineni			

ACUTE FEBRILE ILLNESS WITH THROMBOCYTOPENIA
HEPATIC INSUFFICIENCY

C/o fever associated with chills and rigors, headache and body pains since 5 days

AT ADMISSION:
Afebrile
PR: 82/min
BP: 120/80mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 96%
P/A: Soft

A 33 years old male patient Mr. SHIVA KUMAR J came with c/o fever associated with chills and rigors, headache and body pains since 5 days. All necessary investigations were done and diagnosed as ACUTE FEBRILE ILLNESS WITH THROMBOCYTOPENIA, HEPATIC INSUFFICIENCY. Managed conservatively. Patient condition and need for further hospitalization clearly explained to patient attendants but they want to leave against medical advice so patient being discharged under LAMA.

54405

C/o fever since 4 days associated with cough and cold.

ON ADMISSION VITAL

Patient conscious, coherent
Temp-101'f
PR-86/min
BP-140/80mmhg
RR-20/min
RS-BAE+,
CVS-S1S2+
P/A-Soft, BS+
SPO2-92% at RA.

K/C/O TYPE II DIABETES MELLITUS.

A 65 years old male patient Mr. S RAMCHANDER is a k/c/o TYPE II DIABETES MELLITUS presented to ER with c/o fever since 4 days associated with cough and cold. All necessary investigations were done and diagnosed as LOWER RESPIRATORY TRACT INFECTION. (COVID-19 POSITIVE). SEVERE ACUTE RESPIRATORY INFECTION. CORADS - 5. Patient was treated symptomatically and condition improved. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:
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1. TAB. LIMCEE 500MG 1TAB TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.
2. TAB. PREDMET 4MG 1TAB TWICE DAILY AT 8AM AND 8PM FOR 5DAYS.
3. TAB. ZINC 50MG 1TAB ONCE DAILY AT 8AM FOR 10DAYS.
4. TAB. PULMOCLEAR 1TAB TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.
5. TAB. BILAZEP 20MG 1TAB ONCE DAILY AT 2PM FOR 7DAYS.
6. GLUTAUP SACHET TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
7. TAB. PANTOCID L 40/75MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 15 DAYS.
8. TAB. FEROALFA CV TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
9. TAB. LINOPIK OD 1200MG ONCE DAILY AT 2PM FOR 5 DAYS.
10. CONTINUE OWN DIABETIC MEDICINE AS BEFORE.

REVIEW AFTER 15 DAYS TO GENERAL MEDICINE OPD WITH FBS, PLBS REPORTS.

HIGH PROTEIN & HIGH ANTIOXIDANT DIET
ENSURE DM 2 SCOOPS IN 100ML WATER OR MILK TWICE A DAY

FBS, PLBS REPORTS.

HOME ISOLATION FOR 15 DAYS.
USE MASK, SPIROMETRY.
WATCH FOR SATURATION WITH PULSE OXYMETER IF <90% COME TO HOSPITAL.
REST

IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS, PLEASE CONTACT YOUR DOCTOR OR FOLLOWING NUMBER I.E 0878-2200000 / 9963145554 / 7995362052.
1) FEVER OF 101’F
2) ONSET OF NEW PAIN OR WORSENING OF PREVIOUS PAIN.
3) VOMITING.
4) BREATHING DIFFICULTY, DEVELOPING BLUISH DISCOLOURATION OF LIPS/FACE.
5) ALTERED LEVEL OF CONSCIOUSNESS.
6) DISCHARGE FROM THE OPERATIVE WOUND (IF ANY).
7) WORSENING OF ANY SYMPTOMS.
8) OTHER SIGNIFICANT CONCERNS.

9) POST COVID-19, COMPLICATIONS RELATED TO BLOOD CLOTTING AND NEUROLOGICAL DEFICITS HAVE BEEN SCIENTIFICALLY DOCUMENTED AS POSSIBLE COMPLICATIONS.
10) PLEASE REPORT TO THE EMERGENCY IN CASE OF ANY SYMPTOMS LIKE PERSISTENT PAIN/PRESSURE IN THE CHEST, MENTAL CONFUSION, DROWSINESS OR INABILITY TO AROUSE, SLURRED SPEECH/SEIZURES, WEAKNESS OR NUMBNESS IN ANY LIMB OR FACE, SWELLING OF LOWER LEG/FEET OR ANY OTHER CONCERN.
ANTIBIOTICS ARE SCHEDULED DRUGS UNDER LAW, NEVER SELF MEDICATE OR USE ANTIBIOTICS WITH OUT DOCTORS PRESCRIPTION."

YOU WOULD ALSO HAVE RECEIVED DETAILS OF THE APOLLO PROHEALTH FOLLOW UP CHECK-UP PLAN WHICH HAS BEEN DESIGNED BY OUR EXPERTS ESPECIALLY TO ENSURE YOUR HOLISTIC RECOVERY FROM COVID-19 INCLUGING POST-RECOVERY REHABILITATION AND RETURN TO THE FULLEST OF HEALTH. PLEASE CONTACT 0878-2200000 / 9963145554 / 7995362052 FOR AN APPOINTMENT FOR PROHEALTH FOLLOWUP CHECKUP PLAN.

ARH1.0001226675		**Name**	Mrs. BANDARI LAXMI
Patient Identifier	ARHIP54379	**Age**	50Yr 2Mth 16Days
Sex	Female	**Date of Admission**	18-Jan-2022
Date of Discharge			
MLC No			
Address	1-17, NAGIREDDYPUR KARIMNAGAR 8985076130,Telangana	**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 3
Primary Consultant	Dr SOMASHEKAR K(MS		

SURGERY: DVR [MVR WITH SJ NO. 27 MM & AVR WITH SJ NO. 21MM MECHANICAL VALVES] DONE ON 25/01/2022.

CHRONIC RHEUMATIC HEART DISEASE + SEVERE AS+ MILD AR, MODERATE MS WITH MR+MODERATE LV DYSFUNCTION+HYPOTHYROIDISM
ACUTE INFARCTS IN RIGHT MCA TERRITORY

C/o shortness of breath on exertion since 10 days

AT ADMISSION:
Pt c/c
Afebrile
PR: 88/min
BP: 120/80mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 99%
P/A: Soft

A 50 years old female patient Mrs. BANDARI LAXMI came with c/o shortness of breath on exertion since 10 days. All necessary investigations were done and diagnosed as CHRONIC RHEUMATIC HEART DISEASE + SEVERE AS+

MILD AR, MODERATE MS WITH MR+MODERATE LV DYSFUNCTION+HYPOTHYROIDISM, ACUTE INFARCTS IN RIGHT MCA TERRITORY, SURGERY: DVR [MVR WITH SJ NO. 27 MM & AVR WITH SJ NO. 21MM MECHANICAL VALVES] DONE ON 25/01/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, she is being discharged with required medication and advice.

POST DVR 2D ECHO REPORTS SHOWED POST DVR STATUS , CONCENTRIC LVH,
GLOBAL HYPOKINESIA OF LV, MODERATE LV DYSFUNCTION, NO CLOT/PE/VEG

BMI is 13.1 kg/m2.

Sr. Creatinine report on 26/01/2022 0.7 mg/dl.

DISCHARGE MEDICATION:
---
1) TAB. ACITROM 1MG ½ TAB AND 1 TAB ALTERNATE DAY AT 7PM TO CONTINUE
2) TAB. RIVOTRIL 0.5 MG ONCE DAILY AT 8PM TO CONTINUE.
3) TAB. MET-XL 25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
4) TAB. ELTROXIN 25MCG ONCE DAILY AT 8AM TO CONTINUE.
5) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
6) TAB. ENCORATE CHRONO 500MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
7) TAB. TELMA 20 MG ONCE DAILY AT 8AM TO CONTINUE.
8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
9) TAB. ROXSAFE CV 500+125 MG ONCE DAILY AT 8AM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT/INR REPORTS
REVIEW AFTER 3 MONTHS TO NEUROPHYSICIAN’S OPD

54514 pochamma 68

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NO TLT
SR, MODERATE LV DYSFUNCTION, EF-40%
CORONARY ANGIOGRAM DONE ON 28/01/2022 – CAD-SVD (LAD)
PTCA+DES TO LAD WITH 3.5 X 24 MM METAFOR DONE ON 28/01/2022
R/F: HTN,T2DM

C/o Epigastric (chest) pain radiating to back associated with shortness of breath

K/C/O HTN,T2DM

AT ADMISSION:
Afebrile
PR: 84/min
BP: 100/70mmHg
RS: BAE+
CVS: S1S2
RR: 20/min
SPO2: 93%
P/A: Soft

A 68years old female patient POCHAMMA came with c/o Epigastric (chest) pain radiating to back associated with shortness of breath. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NO TLT, SR, MODERATE LV DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 28/01/2022 – CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 24 MM METAFOR DONE ON 28/01/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:
---
1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
3) TAB. CILODOC 50MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
5) TAB. BETOLOC 25MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
6) TAB. RAMISTAR 1.25 MG ONCE DAILY AT 2PM TO CONTINUE.
7) TAB. GLIMSTAR M1 ONCE DAILY AT 8AM TO CONTINUE.
8) TAB. GLIMSTAR M2 ONCE DAILY AT 8PM TO CONTINUE.
9) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
10) INJ HUMAN INSULATARD 8 U S/C TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.
EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.
EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.
SEVERE PAIN AT THE OPERATED SITE.
DISCOLORATION AND SWELLING OF THE OPERATED SITE.
BLEEDING FROM THE OPERATED SITE.
CHEST PAIN.
ACUTE SHORTNESS OF BREATH.
ALTERED LEVEL OF CONSCIOUSNESS.
LOW URINE OUTPUT IN LAST 24 HOURS.
FEVER ABOVE (101'F).
NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.
WORSENING OF ANY OF YOUR SYMPTOMS
ANY OTHER SIGNIFICANT COMPLAINTS.
---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.
---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

54538 lingiaha 59

IT FRACTURE OF RIGHT FEMUR
SURGERY: RIGHT DHS DONE ON 29.01.2022

Alleged to sustained injury due to slip and fall at home on 27/01/2022
c/o pain and swelling over right leg and unable to move

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c
afebrile
PR-80/min
BP-110/70mmhg
RR-18/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-98%

A 59yrs old male patient LINGAIAH came alleged to sustained injury due to slip and fall at home on 27/01/2022, c/o pain and swelling over right leg and unable to move. All necessary investigations done and diagnosed as IT FRACTURE OF RIGHT FEMUR. Surgery: Right DHS done on 29-01-2022. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE IN A DAY AT 8 AM 8 PM FOR 5 DAYS
2. TAB. DOLO 650 MG ONCE IN A DAY AT 2PM FOR 5 DAYS
3. TAB. MULTIVITAMIN ONCE IN A DAY AT 2PM FOR 10 DAYS

Review after 11 days with Dr. Ifthekar Ali’s OPD.

ARH1.0001225775		**Name**	Mr. PAMBALA AILAIAH ..		
	Patient Identifier	ARHIP54540		**Age**	30Yr 0Mth 11Days
	Sex	Male		**Date of Admission**	28-Jan-2022
	Date of Discharge				
	MLC No				
	Address	4-26/1, APPANNAPET PEDDAPALLI 9704351042,Telangana		**Ward/ Bed No**	Second Floor, Semi Private, Bed no:118 B
	Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS),Consultant Urologist)--UROLOGY			

RIGHT RENAL CALCULUS
SURGERY: RIGHT PCNL + DJ STENT DONE ON 29.01.2022

C/O right loin pain, burning micturition since 1week.

ON ADMISSION

Pt c/c
Afebrile
PR-82/min
BP-120/80mmhg
RR-20/min
RS-BAE+,
CVS-S1S2+
P/A-Soft,

A 30 yr old male patient came with C/O right loin pain, burning micturition since 1week. All necessary investigations were done and diagnosed as RIGHT RENAL CALCULUS, SURGERY: RIGHT PCNL + DJ STENT DONE ON 29.01.2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION

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1) TAB. ROXSAFE CV TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
2) TAB. DOLO 650MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
3) TAB. ND Q10 ONCE DAILY AT 2PM FOR 11 DAYS.
4) TAB. PAN 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 11 DAYS.
5) SYP. K-CIT 10 ml TWICE DAILY AT 8AM AND 8PM

Review after 11 days to urologist OPD.
Review after 3 week for DJ stenting removal.

ARH1.0001168414		**Name**	Mr. THRELOCHEN BONTHALA
Patient Identifier	ARHIP54526	**Age**	58Yr 1Mth 16Days
Sex	Male	**Date of Admission**	27-Jan-2022
Date of Discharge			
MLC No			
Address	8-1-81,KATTARAMPOOR,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Female General Ward, Bed no:GW 2
Primary Consultant	DR. SANJAY KUMAR KAMINWAR		

ACUTE INFARCT IN LEFT MCA TERRITORY

C/o weakness of right upper limb and lower limb since 4 days

AT ADMISSION:
Afebrile
PR: 96/min
BP: 110/60mmHg
RS: BAE+
CVS: S1S2
RR: 20/min
SPO2: 98%
P/A: Soft

A 58 yrs old male patient Mr. THRELOCHEN BONTHALA came with the c/o weakness of right upper limb and lower limb since 4 days. All necessary investigations done and diagnosed as ACUTE INFARCT IN LEFT MCA TERRITORY. Conservative medical management given. Patient symptomatically improved. She is being discharged in a haemodynamically stable condition with discharge medication and advice.

DISCHARGE MEDICATION:

1. TAB: PREVA-AS 75 MG ONCE DAILY AT 2PM FOR 11DAYS.
2. TAB: COLTRO 10 MG ONCE DAILY AT 8PM FOR 11DAYS.

REVIEW AFTER 11 DAYS IN DR. SANJAYKUMAR'S OPD.

ARHIP54485

L3-L4 ACUTE DISC EXTRUSION WITH PARAPARESIS.
SURGERY : L3 LAMINECTOMY AND L3/L4 DISCECTOMY DONE ON 26.01.2022.

C/o low back ache right and left lower limb numbness, unable to stand and walk since 1month.
Patient had severe pain while sitting and radiating to both lower limbs (right more than left)

ON ADMISSION

Pt c/c
Afebrile
PR-96/min
BP-170/100mmhg
RR-20/min
RS-BAE+,
CVS-S1S2+
P/A-Soft, BS+
SPO2-99%

Power upper limb- 5/5
Power lower limb- Distal 3/5, proximal 3/5,
B/l foot drop

A 67 years old male patient Mr. CH PRAKASH is a presented to hospital with c/o low back ache right and left lower limb numbness, unable to stand and walk since 1month. Patient had severe pain while sitting and radiating to both lower limbs (right more than left). All necessary investigations were done and diagnosed as L3-L4 ACUTE DISC EXTRUSION WITH PARAPARESIS. Neurosurgeon consultation taken, planed for surgery. Patient underwent Surgery of L3 LAMINECTOMY AND L3/L4 DISCECTOMY DONE ON 26.01.2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION
---
1) TAB. CETIL 500MG TWICE DAILY AT 8AM AND 8PM FOR 7DAYS.
2) TAB. GABNTIP-AT 100/10 MG ONCE DAILY AT 8PM(HS) FOR 7 DAYS.
3) TAB. RANTAC 150MG TWICE DAILY AT 7AM AND 7PM (BEFORE FOOD) FOR 7 DAYS.
4) TAB. REJUNEX CD3 ONCE DAILY AT 8AM AND 8PM FOR 7 DAYS.
5) TAB. NUREWIRE TWICE DAILY AT 8AM AND 8PM FOR 7DAYS.
6) TAB. TOLVAPTAN 15MG TWICE DAILY AT 8AM AND 8PM FOR 7DAYS.
7) TAB. TOLPERISONE 150MG ONCE DAILY AT 8PM(HS) FOR 5 DAYS.
8) TAB. TELMA-H 40 MG ONCE DAILY AT 8PM(HS) TO CONTINUE
9) TAB. PROLOMET-XL ONCE DAILY AT 8AM TO CONTINUE

REVIEW AFTER 7 DAYS TO NEUROLOGY OPD.

ARH1.0001227239		**Name**	Mr. N RAMCHANDER
Patient Identifier	ARHIP54561	**Age**	72Yr 0Mth 3Days
Sex	Male	**Date of Admission**	31-Jan-2022
Date of Discharge			
MLC No			
Address	,,Ramagundam,Telangana	**Ward/Bed No**	First Floor, RECOVERY ROOM, Bed no:RR 6
Primary Consultant	Dr. GOUTHAM ROY		

RIGHT INGUINAL HERNIA
SURGERY: RIGHT INGUINAL HERNIOPLASTY DONE ON 01/02/2022

C/O swelling in right inguinal region since 1month.

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c
afebrile
PR-80/min
BP-110/70mmhg
RR-18/min
RS-BAE+
CVS-S1S2+
CNS-NAD.
SPO2-98%

A 72yr old male Mr. N RAMCHANDER came with c/o swelling in right inguinal region since 1month. All necessary investigations done and diagnosed as RIGHT INGUINAL HERNIA, SURGERY: RIGHT INGUINAL HERNIOPLASTY DONE ON 01/02/2022. Findings: Indirect long studing sac noted with small bowel loops as its contents. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: VELTAMPLUS ONCE DAILY AT 2PM FOR 15 DAYS.
5. GLUTAVAULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

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ARH1.0001227116	**Name**	Mr. B NARAYANA			
	Patient Identifier	ARHIP54523		**Age**	43Yr 0Mth 6Days
	Sex	Male		**Date of Admission**	27-Jan-2022
	Date of Discharge	02-Feb-2022			
	MLC No				
	Address	ESALATHAKKALAPALLI,PEDDAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, SICU, Bed no:SICU 5
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, AWMI, NO TLT
MODERATE LV DYSFUNCTION, EF-35%
CORONARY ANGIOGRAM DONE ON 29/01/2022 – CAD-DVD (LAD, LCX)
PTCA+DES TO LAD, LCX WITH 3.0 X 29 MM METAFOR TO LAD, 2.75 X 19 MM METAFOR TO LCX DONE ON 31/01/2022

C/o left sided chest pain a/w SOB since 1 day

AT ADMISSION:
Afebrile
PR: 81/min
BP: 120/80mmHg
RS: BAE+
CVS: S1S2
RR: 20/min
SPO2: 98%
P/A: Soft

A 43 years old male patient Mr. NARAYANA came with c/o left sided chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, NO TLT, MODERATE LV DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 29/01/2022 – CAD-DVD (LAD, LCX), PTCA+DES TO LAD, LCX WITH 3.0 X 29 MM METAFOR TO LAD, 2.75 X 19 MM METAFOR TO LCX DONE ON 31/01/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

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1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
3) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
4) TAB. BETALOC 25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5) TAB. RAMISTAR 2.5MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
6) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.
7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.
EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.
EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.
SEVERE PAIN AT THE OPERATED SITE.
DISCOLORATION AND SWELLING OF THE OPERATED SITE.
BLEEDING FROM THE OPERATED SITE.
CHEST PAIN.
ACUTE SHORTNESS OF BREATH.
ALTERED LEVEL OF CONSCIOUSNESS.
LOW URINE OUTPUT IN LAST 24 HOURS.
FEVER ABOVE (101'F).
NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.
WORSENING OF ANY OF YOUR SYMPTOMS
ANY OTHER SIGNIFICANT COMPLAINTS.
---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.
---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001172495		**Name**	Mrs. SUSHILA GANTA		
	Patient Identifier	ARHIP54576		**Age**	63Yr 11Mth 1Days
	Sex	Female		**Date of Admission**	01-Feb-2022
	Date of Discharge				
	MLC No				
	Address	10-4-39, VAVILALAPALLI,Karimnagar,Telangana		**Ward/ Bed No**	First Floor, CICU , Bed no:CICU 2
	Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

AF WITH CVR,
MILD MR
NORMAL LV SYSTOLIC FUNCTION [EF-60%]
R/F : HTN

C/o sudden onset of giddiness and vomiting

K/c/o HTN

AT ADMISSION:
Pt conscious, coherent
Afebrile
PR: 84/min
BP: 130/80mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 98%
P/A: Soft

A 63 years old female patient Mrs. SUSHILA GANTA came with c/o sudden onset of giddiness and vomiting. All necessary investigations were done and diagnosed as AF WITH CVR,
MILD MR, NORMAL LV SYSTOLIC FUNCTION [EF-60%]. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:
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1. TAB. MET-XL 25 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. IXAROLA 15 MG ONCE DAILY AT 8PM AFTER DINNER TO CONTINUE.
3. TAB. PANTOCID-L 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
4. SYP. POTKLOR 15 ml THRICE DAILY AT 8AM 2 PM 8 PM FOR 5 DAYS
5. TAB. VERTIN 16 MG TWICE DAILY AT 8AM 8PM FOR 10 DAYS.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

ARH1.0001226819		**Name**	Mrs. K KAMALAMMA
Patient Identifier	ARHIP54537	**Age**	65Yr 0Mth 13Days
Sex	Female	**Date of Admission**	28-Jan-2022
Date of Discharge			
MLC No			
Address	GARREPALLI,Karimnagar,Telangana	**Ward/Bed No**	Second Floor, Semi Private, Bed no:103 A
Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Consultants**	
Surgeons	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Add Diagnosis

ARHIP54537	ARH1.000122681

Surgery / Procedures Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
LAPROSCOPIC CHOLECYSTECTOMY				

GALL STONE DISEASE
SURGERY: LAPAROSCOPIC CHOLECYSTECTOMY DONE ON 31/01/2021

C/o right hypochondrial pain

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c
afebrile
PR-80/min
BP-110/70mmhg
RR-18/min
RS-BAE+
CVS-S1S2+
P/A-Soft
CNS-NAD.
SPO2-98%

A 65yrs old female KAMALAMMA came with c/o right hypochondrial pain. All necessary investigations done and diagnosed as GALL STONE DISEASE SURGERY: LAPAROSCOPIC CHOLECYSTECTOMY DONE ON 31/01/2021. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence she is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPRAZ-L TWICE DAILY AT 8AM 8PM FOR 15 DAYS.
5. GLUTAVAULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.
6. SYP. SUCRAFIL-O 2tsp THRICE DAILY AT 8AM 2PM 8PM
7. TAB: SINAREST TWICE DAILY AT 8AM 8PM FOR 2 DAYS.

Review after 10 days in General Surgery OPD.

ARH1.0001226625		**Name**	Mrs. POSHAKKA KUKATKAR		
	Patient Identifier	ARHIP54351		**Age**	62Yr 0Mth 12Days
	Sex	Female		**Date of Admission**	16-Jan-2022
	Expired Date	28-Jan-2022			
	MLC No				
	Address	1 GUDEM,Karimnagar,Telangana		**Ward/Bed No**	First Floor, CT POST, Bed no:CT 5
	Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant -Cardio Thoracic & Vascular Surgeon)--C T SURGERY		**Consultants**	
	Surgeons	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant -Cardio Thoracic & Vascular Surgeon)--C T SURGERY		**Anesthesiologists**	Dr. K.S.D.KRISHNA KIRAN--ANAESTHESIOLOGY

Diagnosis

Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE,DOBULE VESSEL DISEASE,SEVERE LV DYS FUNCTION,ACUTE RENAL FAILURE,VENTICULAR TACHYCARDIA,HYPERTENTION,RECENT AWMI. SURGERY;S/P CORONARY ARTERY BYPASS GRAFTING(LIMA-LAD,SVG-PDA)DONE ON 21/1/2022.	

C/o chest pain since 3days

AT ADMISSION:
Afebrile
PR: 80/min
BP: 120/80mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 98%
P/A: Soft

A 62 years old female patient Mrs. POSHAKKA KUKATKAR came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE,DOBULE VESSEL DISEASE,SEVERE LV DYS FUNCTION,ACUTE RENAL FAILURE,VENTICULAR, TACHYCARDIA,HYPERTENTION,RECENT AWMI. SURGERY;S/P CORONARY ARTERY BYPASS GRAFTING(LIMA-LAD,SVG-PDA)DONE ON 21/1/2022. Post-op period was uneventful. On 28/01/2022 at 3.10 pm patient had brady cardia, patient was intubated and connected mechanical ventilator. CPR started immediately according to ACLS guidelines, Inj.Adrenaline and Inj Atropine given, Rhythm was pulseless. CPR continued. inj. Adrenaline repeated of 3-5 min
CPR continued for another 30 min, Despite efforts, patient could not be revived back, rhythm was asystole, ECG showed flat lines, Pupils-b/l dilated and fixed. Patient was declared as dead at 04.03 PM on 28.01.2022.

CAUSE OF DEATH

CORONARY ARTERY DISEASE,DOBULE VESSEL DISEASE,SEVERE LV DYS FUNCTION,ACUTE RENAL FAILURE,VENTICULAR TACHYCARDIA,HYPERTENTION,RECENT AWMI. SURGERY;S/P CORONARY ARTERY BYPASS GRAFTING(LIMA-LAD,SVG-PDA)DONE ON 21/1/2022.

ARH1.0001226755		**Name**	Mr. GANGADHAR MUSCAM
Patient Identifier	ARHIP54387	**Age**	61Yr 0Mth 8Days
Sex	Male	**Date of Admission**	19-Jan-2022
Expired Date	26-Jan-2022		
MLC No			
Address	H.NO:2-94,MADHAPUR,KORUTLA,JAGITIAL,Other,Telangana	**Ward/Bed No**	First Floor, CICU , Bed no:CICU 7
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	**Consultants**	
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	**Anesthesiologists**	

Diagnosis

Diagnosis

Disease	Disease Type
CAD ACUTE AWMI,NO TLT SR,SEVERE LV SYSTOLIC DYSFUNCTION EF:30% RF:T2DM.	

C/o sudden onset of chest pain, associated with shortness of breath grade-II since 2 days
Known case of type II DM on regular medication

AT ADMISSION:
Afebrile
PR: 112/min
BP: 90/60mmHg
RS: BAE+
CVS: S1S2
RR: 20/min
SPO2: 99% with 4 Lit O2
P/A: Soft

A 61 years old male patient Mr. GANGADHAR MUSCAM came with c/o sudden onset of chest pain, associated with shortness of breath grade-II since 2 days. Known case of type II DM on regular medication. All necessary investigations were done and diagnosed as CAD ACUTE AWMI,NO TLT SR,SEVERE LV SYSTOLIC, DYSFUNCTION EF:30%, RF:T2DM. On 26/01/2022 Patient was drowsy restlessness, he was desaturated immediately NIV support given, inotropic support were done. 200 j of DC shock is given for 45 minutes. CPR given according to ACLS guidelines INJ. ADRENALINE, INJ. ATROPINE were given. In spite of all efforts patient not reverted. ECG done and it was a flat line. Patient declared death at 7.13 AM on 26/01/2022

CAUSE OF DEATH

CAD ACUTE AWMI,NO TLT SR,SEVERE LV SYSTOLIC DYSFUNCTION EF:30%
RF:T2DM.

ARH1.0001226616		**Name**	Mrs. JAYALAXMI SILIVERI		
	Patient Identifier	ARHIP54345		**Age**	42Yr 0Mth 9Days
	Sex	Female		**Date of Admission**	15-Jan-2022
	Expired Date	24-Jan-2022			
	MLC No				
	Address	5-38/2, BHITPALLE PEDDAPALLI,Telangana		**Ward/Bed No**	First Floor, SICU, Bed no:SICU 4
	Primary Consultant	DR. SUBRAT KUMAR SOREN --NEUROSURGERY		**Consultants**	
	Surgeons	DR. SUBRAT KUMAR SOREN --NEUROSURGERY		**Anesthesiologists**	Dr Subba Reddy Kuppannagari--ANAESTHESIOLOGY

Cause of Death

Cause of Death

Diagnosis

Diagnosis

Disease	Disease Type
1.LEFT CAPSULOGANGLIONIC BLEED 2.STATUS POST LFET FRONTO TEMPOROPARIETAL DECOMPRESSIVE CRANIECTOMY ON 15/01/2022 3.CHRONIC KIDNEY DISEASE	

History of collapse associated with seizures at 5 p.m. on 15/01/2022
Known case of hypertension not on regular medication

AT ADMISSION:
Afebrile
PR: 91/min
BP: 180/100mmHg
RS: BAE+
CVS: S1S2
RR: 20/min
SPO2: 98%
P/A: Soft

A 42 yrs old female patient Mrs. JAYALAXMI SILIVERI came to hospital with history of collapse associated with seizures at 5 P.M. on 15/01/2022. Known case of hypertension not on regular medication. All necessary investigations done and diagnosed as 1.LEFT CAPSULOGANGLIONIC BLEED, 2.STATUS POST LFET FRONTO TEMPOROPARIETAL DECOMPRESSIVE CRANIECTOMY ON 15/01/2022, 3.CHRONIC KIDNEY DISEASE. Post decompression surgery, patient was on ventilator (VC/AC mode) in view of low GCS. Also patient was on ionotropic support for hypotension. On dated 24/01/22 patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 04.27 AM on 24/01/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO LEFT CAPSULOGANGLIONIC BLEED, STATUS POST LFET FRONTO TEMPOROPARIETAL DECOMPRESSIVE CRANIECTOMY ON 15/01/2022, CHRONIC KIDNEY DISEASE.

ARH1.0001226585		**Name**	Mrs. AFZAL BHI
Patient Identifier	ARHIP54386	**Age**	64Yr 0Mth 21Days
Sex	Female	**Date of Admission**	19-Jan-2022
Date of Discharge			
MLC No			
Address	PEDDAPALLI,Other,Telangana	**Ward/ Bed No**	First Floor, CT POST, Bed no:CT 2
Primary Consultant	Dr SOMASHEKAR K		